

**INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE
DEATH OF MAN AT HMP LEEDS IN MAY 2006**

**Report by the Prisons and Probation Ombudsman for
England and Wales**

January 2008

This is the report of an investigation into the death of a man at HMP Leeds in May 2006. In March his bizarre and aggressive behaviour resulted in him being charged with a serious offence. He was initially sectioned under the Mental Health Act and then remanded to HMP Leeds.

The man was discovered late at night, hanging in a standing position, suspended by a bed sheet tied to the cell window. His cellmate alerted staff who cut the man down and commenced resuscitation. He was pronounced dead in his cell by paramedics. The man's cellmate was subsequently charged with the man's murder, but later pleaded guilty to the lesser offence of aiding and abetting suicide. He has been sentenced to ten years' imprisonment.

I offer my sincere condolences to the man's family and friends. I hope that this report answers their questions, but recognise that it may not alleviate their pain or lessen their grief. My report has been delayed in order that the criminal investigation could be completed, and I appreciate the man's family's patience throughout. A key objective of my investigation has been to give every opportunity for them to raise any concerns about his death. One of my family liaison officers and the investigator met representatives of his family, and we have done all we can to answer their questions.

The investigation was undertaken on my behalf by two investigators from my office. I would like to express my thanks to the Governor of Leeds and his staff for the help and active co-operation that my investigators received throughout the investigation. I also thank the Governor of Wakefield for providing important documents about the man's cellmate.

I have been assisted by Her Majesty's Chief Inspector of Prisons (HMCIP) most recent report on an inspection at Leeds, which took place in August 2005. I commissioned a clinical review which was undertaken by a doctor of Leeds West Primary Care Trust. I am grateful to him for his assistance. I also thank the Detective Superintendent and the Detective Inspector of West Yorkshire Police who conducted the criminal investigation and willingly shared their information.

The circumstances of the man's death are deeply distressing. He was a vulnerable man. Like his family, I am concerned how he came to share a cell with a prisoner who, in the words of the sentencing judge, is an "extremely dangerous" man. The judge commented that the cellmate drove the man to take his own life by systematically bullying him. My investigators found deficiencies in Leeds' system for allocating prisoners to appropriate cells. I have found the same failing previously and again since the man's death. I also make two other recommendations.

This version of the report has been anonymised for publication on the PPO website.

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Prisons and Probation Ombudsman

January 2008

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SUMMARY

In March 2006, the man was arrested for a serious sexual offence. He was experiencing mental health problems and agreed to psychiatric treatment, under the Mental Health Act. On 27 April, the Mental Health Act section was discharged and he was re-arrested for the offence. The following day he appeared at the Magistrates' Court and was remanded to HMP Leeds.

The man was assessed by healthcare staff in reception, and it was noted that he had been a mental health patient and been prescribed anti-psychotic medication. No other significant medical history was identified.

Due to the nature of his offence, he applied for Vulnerable Prisoner status and was located in the First Night Centre, D wing. The following day he was transferred to the Vulnerable Prisoners Unit on A wing. He was also assessed by the Safer Custody Unit, who identified his vulnerability but considered it insufficient to warrant on-going monitoring.

On 30 April, the man was moved from cell A4:28 to A3:25, but his new cellmate complained that he was acting strangely and asked for him to be moved again. He was transferred to A4:02, a cell he shared with his last cellmate. The man's cellmate was a life sentence prisoner, with a history of violent behaviour. He was assessed as a medium risk to cellmates, which meant that he could share a cell subject to regular reviews.

Two days later the Crown Court ruled that the man should be bailed to a probation hostel, but no suitable beds were available and so he returned to the prison. He appeared in court again three days later, to be told that he could be bailed to a hostel outside West Yorkshire. Again no beds were available and he therefore returned to custody. His case was re-listed for 10 May, by which time it was hoped that a suitable place would be available.

On 8 May, the man spoke in confidence to a Listener. Listeners are trained to provide confidential emotional support to fellow prisoners in distress. He told the Listener that his cellmate was threatening to kill him, but he refused to allow his fears to be reported.

At 11.10pm the next evening, three staff heard a prisoner calling for help for his cellmate. The officers saw the man hanging from a ligature attached to the window and went in. The cellmate was removed and attempts were made to resuscitate the man. Paramedics arrived promptly, but their efforts were unsuccessful and the man was pronounced dead.

The man's cellmate spoke to the duty governor on 12 May, saying that he needed to speak to the police as he had been involved in the man's death. The man's cellmate was arrested and charged with murder, before being convicted on 22 February 2007 of aiding and abetting the man's suicide at the Crown Court. The circumstances of the evidence against the man's cellmate were given publicly in court. He was sentenced to ten years' imprisonment.

CONDUCT OF THE INVESTIGATION

1. One of my investigators visited Leeds to open the investigation on 12 May 2006, two days after the man's death. The investigation was conducted by two of my investigators, which began after the man's cellmate was sentenced.
2. Notices were issued to staff and prisoners telling them of the investigation, and offering the opportunity to participate. My investigators obtained the records relating to the man's imprisonment, and obtained copies of relevant documents relating to his cellmate. They received full cooperation from West Yorkshire Police, who allowed full sight of all statements obtained from staff and prisoners. They also had sight of the prosecution case report against the man's cellmate.
3. My investigators also had access to the reports written following the deaths of prisoners at Leeds in 2004, 2005 and 2006, and to the reports of inspections by Her Majesty's Chief Inspector of Prisons (HMCIP). Their findings are of importance, and have been used throughout this report.
4. An independent clinical review of the medical care the man received in HMP Leeds has been provided by a doctor of Leeds West Primary Care Trust.
5. One of my family liaison officers and the lead investigator met representatives of the man's family on 19 June 2006. My investigation attempts to answer their questions, which particularly referred to the man's location in the prison and whether it was properly assessed to meet his needs:
 - Why was he located on a normal wing when he had just come out of hospital and had mental health problems?
 - What are the criteria for location on the hospital wing, and whether the man was suitable?
 - How many cells and cellmates did the man have and what necessitated the moves?
 - The man was on remand and the family are concerned that, even though he was not convicted, he was put in a cell with a prisoner serving a life sentence.
 - How were the risks of cell sharing carried out, what did they show, and how did the man come to be located with his cellmate? They believe that this was inappropriate as the cellmate was known to be dangerous.
 - Was the cellmate known to be a risk to alleged or convicted sex offenders?
 - There were obvious ligature points within the cell.
6. The man's family also raised important questions about the prison's knowledge of his health needs and the healthcare he received within the prison. In particular they said they would have serious concerns if his mental health needs were not identified. They told my colleagues that a barrister, who interviewed the man, quickly recognised that he was mentally unwell.

7. The family ask further questions about the man's health and how it was treated:
 - What information was received about the man's needs from external sources, and what he himself disclosed?
 - Whether any information was sought by the prison from external sources, e.g. the hospital or doctor?
 - Whether he was prescribed any medication within the prison?
 - Whether he was assessed by any psychiatric specialists within the prison?

8. Finally the man's family asked about the conditions he was held in and the way in which they were notified of his death:
 - The man had told his family that prisoners were locked up for 23 hours each day, and they ask for information about the daily regime.
 - The family would like to know more about how the alarm was raised, and the response to the alarm.
 - The family were concerned that the man's elderly mother was telephoned at 5.15am, and asked for her address. They want to know whether the man was asked to provide information about his next of kin.
 - The man's mother was visited by the deputy governor, and five police cars were in the vicinity.
 - The family would like the investigation to access the press statement released after the man's death, as they are concerned about the extent of the information which became public.

HMP LEEDS

9. HMP Leeds is predominantly a Victorian prison. The four original wings (A, B, C and D) were built in 1847 and two more wings (E and F) were opened in 1994, together with new kitchens, gymnasium and healthcare centre. It is a category B local prison for adult male prisoners from West Yorkshire. The certified normal accommodation in May 2006 was 1,150. The operational capacity was 1,254. On 10 May, 1,101 prisoners were held.
10. In May 2006, there were approximately 400 new prisoners and 4,000 separate prisoner movements through reception. The average stay for a prisoner was 29 days. Over the course of 2006, there were approximately 50,000 prisoner movements in and out of the prison.
11. A Wing consists of four landings, the top three populated by vulnerable prisoners (those who must be protected from others), both convicted and unconvicted. The bottom landing, A1, contains the segregation unit which is known as S1. Other wings hold convicted and unconvicted prisoners, and D wing is the induction wing.
12. Cell A4:02 is a twin occupancy cell on the top landing of A wing. To the left of the cell door is a small toilet, behind a half wall. Directly in front of the doors are two bunk beds, with a table on the left hand wall containing a television and kettle. There is a barred window on the end wall, with two pipes running directly underneath, approximately 18 inches above the floor. The man occupied the top bunk and the man's cellmate the bottom bunk.
13. A dedicated healthcare team comprising 35 nursing staff, 15 healthcare officers, seven pharmacy staff, a practice manager, two clinical directors and a full-time general practitioner deliver a full range of primary medical services. The inpatient unit is staffed 24 hours a day, seven days a week. A mental health team, made up of a psychologist, a consultant psychiatrist and mental health nurses assess those with emotional and psychiatric problems and deliver treatment to those with diagnosed conditions.

Deaths in custody

14. Between April 2004, when I took responsibility for investigating deaths in custody, and May 2006 when the man died, there were 14 deaths at Leeds prison. Of these, six were apparently self inflicted deaths and one was due to homicide, the others being due to natural causes or substance misuse. Three of the men who apparently took their own lives died in the normal wings and three in the segregation unit.
15. The system for monitoring and supporting prisoners who are at risk of suicide or self harm was the F2052SH form. This has been superseded by the Assessment, Care in Custody and Teamwork (ACCT) document. The ACCT document is designed to provide individual care planning for prisoners. Once

placed on ACCT, the vulnerable prisoner is observed by staff at predetermined regular intervals and engaged with in a structured way, in order to reduce the risk they pose to themselves.

16. Selected prisoners are trained by the Samaritans to act as Listeners and provide support on request for other prisoners. Listeners are bound by the Samaritans' code of confidentiality.

Cell Sharing Risk Assessments

23. Since 2002, the Prison Service has used Cell Sharing Risk Assessments (CSRA) to identify those prisoners who should not share cells with others. Its origins lay in a judgement by the European Court of Human Rights in a case brought by the parents of a murdered prisoner. The court found that the Prison Service was in breach of article 2 of the European Convention on Human Rights (ECHR), in that it failed to have in place an adequate risk assessment procedure.
24. The risk assessment system introduced by Prison Service Instruction (PSI) 26/2002 sought to:
 - draw together and pool information about risk from operational and health care staff
 - make best use of documentary evidence
 - support staff judgements about allocation to cells
 - where cell sharing is unavoidable for a high risk prisoner, provide for senior managers to decide and record additional operational precautionary measures
 - provide a readily accessible record about risk of harm to others as a prisoner moves between wings/prisons
 - record decisions about managing and reviewing risk to enable early identification of racist, homophobic or violent prisoners to ensure that other Prison Service procedures to protect potential victims are followed.
25. Form XF001 was introduced to record the risk and was intended to be a live document, revisited whenever a prisoner's location was being reconsidered. The PSI states that prisoners with ratings other than high need only be reviewed when they are transferred, change their cell or their circumstances change.
26. The User Guide issued with the PSI defines the levels of risk as:
 - High – Clear indication of high level of risk that prisoner might assault their cellmate.
 - Medium – No immediate risk, but situation will need to be reviewed regularly. (This rating may also be used where staff feel that there are some signs of risk but there is not enough information available to be sure. Staff are asked to note on the assessment form why they feel there are some signs of risk.)

- Low – No current evidence/indication of risk. Suitable for multi-cell location.
27. A further PSI on cell sharing risk assessment (32/2005) was published in July 2005. It incorporates a review stage into the dynamic process of assessing risk and a new document, entitled the Cell Sharing Risk Review form, was implemented. This is a two page form which asks the assessor to comment on various aspects of the prisoner's behaviour. The assessor is required to judge the level of risk posed by the prisoner, based on their responses to standard questions. A Cell Sharing Risk Minimisation Plan is required for those assessed as medium or high risk, which should manage and reduce the identified risks and be signed off by the duty governor.

HMCIP INSPECTION

28. Her Majesty's Chief Inspector of Prisons (HMCIP) undertook an unannounced inspection of Leeds between 22 and 26 August 2005. The inspection followed up recommendations made at their previous visit and considered any changes made. Many of their findings are relevant and significant to this investigation.

Visits

29. HMCIP repeated their recommendation about providing visitors with easy access to an efficient booking system. Although the visiting hours were good and there was a new visitor's centre, staffing telephone lines was insufficient to cope with demand and problems were aggravated by delays issuing visiting orders and the absence of a system for prioritising applications.

Bullying

30. Prisoners surveyed by the inspectors reported bullying and intimidation by prisoners and staff, and said that it was not reported because of a lack of confidence in the system. The inspectors noted that there was an appropriate anti-bullying policy, but its implementation was patchy and there were no planned interventions for working with victims. A previous recommendation that all staff should be encouraged to inform the bullying coordinator of all cases of suspected or confirmed bullying had not been achieved and was repeated. Further recommendations were made concerning:
- staff training and use of reporting systems
 - attention to discrepancies between the reports made by each wing
 - training for anti-bullying liaison officers.

SEQUENCE OF EVENTS

Before the man arrived at Leeds

31. The man's cellmate was released from custody on 24 November 2005 with a condition to reside at an approved probation hostel in Wakefield. On 31 December 2005, he cut the alarm system to his bedroom, with the intention of escaping from the hostel later that night. When staff discovered what he had done, he was moved to a vacant bedroom on the ground floor. In the early hours of 1 January 2006, he pulled up the bedroom carpets and lifted the floorboards in his room and piled newspapers, tissues and a duvet into the foundations. He ignited the papers with an aerosol can and a lighter, before dressing and leaving the hostel.
32. He was apprehended by the police and charged the following day with arson with intent to endanger life. He told the police that he had set the fire to kill two of the hostel residents. He appeared in court on 3 January, and was remanded into custody at Leeds.
33. Upon arrival at the establishment, the man's cellmate was subject to the routine reception and induction procedures. He was seen by the reception officer, who completed the Cell Sharing Risk Assessment. As the cellmate was received directly from police custody, the officer only had access to the Prisoner Escort Record (PER) and the warrant for his imprisonment. In order to answer many of the questions on the form, the officer therefore had to rely on information provided verbally by the prisoner. He told her that he had been subject to a 2052SH in 2003/4.
34. The reception officer recorded that the man's cellmate had previous convictions for assault and arson and that his current offence was arson. She documented that he smashed up his cell when he was previously held in a Young Offenders Institution (YOI) and that his current offence involved him setting fire to a hostel. She indicated that he had abused alcohol and drugs and had previously been on a 2052SH, or risk of self-harm document. In total, five of the ten questions which assess risk to others were ticked as relevant. She assessed that he was a low risk for cell sharing, meaning that there was no current indication or evidence of risk and that he was suitable for multi-cell location.
35. After the reception process was completed, the prisoner was transferred to D Wing, which is the induction wing where new prisoners orientate themselves to their new surroundings and familiarise themselves with the prison routine. He was subsequently moved to C wing.
36. On 18 January, the movements officer was working in the movements office on C wing and was responsible for arranging the movement of prisoners for court appearances. Each prisoner is briefly interviewed and the prison's rules and regulations are explained. The officer also refers to the prisoner's Cell Sharing Risk Assessment form.

37. The movements officer noticed that the man's cellmate was classed as low risk for cell sharing, but she disagreed with the assessment. She noted her concerns in his history sheet and expressed them to the wing senior officer (SO). She informed the SO that the prisoner should not be a low risk prisoner and recorded that he should be reviewed.
38. On 20 January, the man's cellmate was moved from C wing to A wing. One of the A wing SO's duties is to deal with prisoner's problems which cannot be solved by other members of staff. Within the first few days of his arrival, the man's cellmate asked for an interview with the SO to request a different cell mate, as he said did not like the man he was with. During the interview he threatened that if he did not get his own way, the SO would regret it. His behaviour was confrontational, abusive and intimidating and he was identified as a problem prisoner and a trouble-maker.
39. One of the prison officers said that the man's cellmate initially arrived on the wing with another prisoner. She described the man's cellmate as quiet and said that he spent most of his time in his cell. After Prisoner A release, another prisoner, prisoner B, was placed in the cell and the prison officer began to notice that the man's cellmate regularly 'had love bites' around his neck.
40. A second prison officer said that when the man's cellmate arrived at the prison, he was subject to an ACCT document and the officer made enquiries about previous self harm. The assessment concluded that he harmed himself for attention from staff and prisoners. He was interviewed again, and assessed as a low risk to himself.
41. Prisoner C had previously shared a cell with prisoner B. He believed that prisoner B and the man's cellmate were having a sexual relationship and were regularly together in the man's cellmate cell. By this time prisoner D was sharing a cell with the man's cellmate and he alleged that the man's cellmate had threatened to set fire to him, so prisoner C suggested that they swap cells.
42. Prisoner B was to transfer to another prison in February and beforehand he told an officer that, in his opinion, the man's cellmate should not share a cell with a paedophile. Prisoner B said that the man's cellmate had told him that he hated paedophiles. My investigators have been unable to trace any record of the report or establish the identity of the officer who prisoner B spoke to and it does not appear that the information was acted upon if it was in fact given to staff.
43. Prisoner B said that the man's cellmate wept when he heard about his transfer, saying that he was worried about sharing with a "dodgy" prisoner. They continued to communicate by letter afterwards, and in one letter prisoner B said that the man's cellmate threatened to cut another prisoner in order to get a transfer and they could be together again.
44. Prisoner E was allocated to share with the man's cellmate. The latter did not like his new cellmate and he became aggressive and disruptive, asking to change cell. He made allegations against prisoner E that were known to be false.

45. Prisoner C was asked to act as a Listener for the man's cellmate. He spoke to him on several occasions, and the man's cellmate made several sexual allegations about prisoner E. Prisoner C noted the allegations and passed them to the second wing SO and the man's cellmate was moved to a single occupancy cell.
46. On one occasion the man's cellmate showed an obscene drawing to a female officer and asked her if she found it offensive. There was an incident in a workshop when he alleged that another prisoner, prisoner F, had hidden a weapon in the workshop, intending to use it on him. He described the weapon as a toothbrush with the head removed and a razor blade melted into the head and produced it from its hiding place. His cell was searched and a tooth brush head with bristles was found. He admitted making the weapon himself, intending to harm himself with it.
47. On 16 February, prisoner G was located to A wing. He knew the man's cellmate from when they lived in the hostel when the arson attempt took place. Within an hour of arriving on the wing, prisoner G was moved to B wing and when he asked the reason, he was told that the man's cellmate had threatened to injure him. A Security Information Report (SIR) was submitted to the Security Department, which detailed the history between the man's cellmate and prisoner G.
48. After three or four days, prisoner G was returned to A wing, without any explanation, even though the man's cellmate was still there. Prisoner G said that he was uncomfortable with the situation and told officers of his concerns. He claimed that no action was taken, and after a while he refused to work as a protest. He was put on report and went in front of a senior officer who showed him a weapon, which consisted of a razor blade fixed to a toothbrush. Prisoner G was told that the weapon had been taken from the man's cellmate and was intended for use on prisoner G.
49. On 20 February, the man's cellmate's Cell Sharing Risk Assessment was reviewed by the third prison officer and signed off by the duty governor. The officer recorded that there was new information to link the prisoner with violent offences, describing it as threats to kill another inmate. He noted that the man's cellmate had displayed homophobic or racist behaviour, described as information that he had a deep hatred of Asians. He was recorded as having displayed anti-social behaviour, bullying, threats, damage to property, aggression, hate-motivated behaviour or assaults. The example was given of his history of threatening to smash up. Finally, the officer confirmed that the prisoner had a long history of self-harm since the age of 12. He was re-assessed as a medium risk to cellmates.
50. The Cell Sharing Risk Minimisation Plan was not completed, although it was recorded that the man's cellmate should be located in shared cell accommodation, and his ACCT observations increased to hourly during night. He was to be considered for a move to B wing Vulnerable Prisoner (VP) overspill. He was subsequently moved to cell A2:25.

51. In March, the fourth prison officer noticed a constant red light above the door and found the man's cellmate lying on the bottom bunk. He had caused a superficial cut to his arm, and said that he had used a blade, which he had disposed of in the toilet. The officer recovered the blade and the prisoner was taken to the nurse who cleaned and dressed the cut. A self harm form was completed outlining the incident.
52. On 17 March, the man who died was arrested for a serious sexual offence. Following his arrest he was found to be experiencing mental health problems and he agreed to voluntary treatment under section two of the Mental Health Act (1983).
53. On 6 April, the man's cellmate was transferred to the Segregation Unit from A wing, following security information that he might be involved in a plan to escape using a fake gun made of matches. He was assessed the following day by a Registered Mental Health Nurse (RMN), who noted no evidence of any psychotic disorder or depression, and he denied any thoughts of self-harm or suicide. He was moved back to A wing on 11 April, and located in cell A4:02 with prisoner H.

Arrival of the man at Leeds

54. On 27 April, the man's Mental Health Act section was formally discharged and he was re-arrested for the offence allegedly committed on 17 March. He spent the night at the police station, before being taken to the Magistrates' Court the next day. He was remanded into custody at HMP Leeds, where he was subject to the normal reception procedures.
55. The man was assessed by a member of the healthcare team at reception. It was noted that he had been an inpatient in a low secure hospital, and prescribed Olanzapine, a widely used anti-psychotic medication. No other significant medical history was noted and the healthcare officer wrote that there was no immediate need for him to see a doctor.
56. As part of the reception process, a Cell Sharing Risk Assessment was completed by the second reception officer. The response to all ten questions regarding a likely risk to other prisoners was negative and the officer wrote that the man said it was his first time in custody. He intended to apply for Vulnerable Prisoner (VP) status. The officer recorded that there was no evidence that he posed a risk to others and he was suitable for a multiple occupancy cell. The man completed the Vulnerable Prisoner application, stating that the reason was the nature of his offence and for his own safety.
57. After completing the reception procedures, the man was moved to D wing, the First Night Centre where he was located in cell D1:22 with prisoner I, another prisoner who had applied for VP status.
58. The following day, 29 April, the wing officer spoke to the man about his application for VP status. The officer recorded that he did not appear to

understand what he had applied for. He explained what being a VP meant and the man's application was approved. The officer wrote that the man 'seems a little cocky and sure of himself'.

59. Later in the day, the man and prisoner I were transferred to A wing where they were located together in cell A4:28. Wing staff explained the rules to him and he signed a compact to demonstrate that he understood them and agreed to abide by them.
60. The man was also assessed by the Safer Custody Unit, which manages prisoners deemed to be at risk of self-harm and suicide. His medical records note that he scored six on the screening tool, used to assess risk of self-harm. The threshold for further intervention is 11, and so he was not subject to any form of self-harm monitoring.
61. On 30 April, the man was moved from cell A4:28 to A3:25, which was occupied by prisoner J. However, the man spent less than a day in the cell before prisoner J asked the second wing officer for him to be moved again. Apparently prisoner J told the officer that the man was talking about strange things, although no details were recorded. The only available bed was in cell A4:02, the man's cellmate cell. The second wing officer said that he checked the man's cellmate Cell Sharing Risk Assessment, and saw that his risk to other prisoners was assessed as low. The man was therefore moved to A4:02.
62. On 2 May, following a bail application by the man's solicitor, a Judge sitting at the Crown Court ruled that the man should be bailed to a probation hostel. However, apparently no suitable places were available, so he could not be released.
63. The man's cellmate attended an education class on 3 May, where the teacher challenged him about his negative attitude towards work. He told her that she should not confront him because he might get angry and take it out on his cellmate. This information was recorded on the man's cellmate History Sheet, but no other action appears to have been taken.
64. On 5 May, the man appeared at the Crown Court. The Judge reiterated that the man could be bailed to a probation hostel so long as it was out of the West Yorkshire area. Again there were no suitable placements available, so he was again returned to custody. His case was re-listed for 10 May, by which time it was hoped that a suitable place would be available.
65. The man's solicitor visited him the following day, 6 May, and noticed that he had shaved his head. The man said that it had taken some time to hack off his hair with a razor blade. He asked his solicitor to get him out of the prison as he said that it was bad. They discussed his bail applications and the solicitor reassured him that he was virtually certain to be bailed on Wednesday 10 May, when he returned to court. The man also told his solicitor that he was sharing a cell with someone serving a life sentence for arson. At the end of the visit the man said he had no cash, and his solicitor said that this should not be a problem as he would shortly be released.

66. Prisoner K acted as a Listener for the man on three occasions, the third meeting taking place on 8 May in the listener's cell. Prisoner K noticed that the man was a little subdued and asked him what was wrong. He replied that he was being bullied by his cellmate and was verbally abused and not allowed to watch television. He said that his cellmate wanted to listen to music, and he would be threatened if he complained. He said he would get his head bitten off and told to shut up. The man began to get upset as he spoke to the Listener, saying that he felt suicidal because of the bullying and threats to kill him. The man broke down in tears, saying he was in fear of his life from his cellmate. Prisoner K asked him if he wanted to inform staff about the situation, but he indicated that he did not want to do so.
67. The first prison officer was on duty on 8 May and standing at the top of the A wing stairs. The man and his cellmate walked past, and the former commented that other inmates had been shouting across the wing at the man. The officer asked what they had been shouting, to which the cellmate replied that it did not matter as they were shouting at him. The officer said that she had not noticed any shouting across the wing.
68. Prisoner G, the prisoner who the cellmate knew from the hostel, recalled the incident in education in early May 2006, when the cellmate made threats about the man, saying that he disliked him as he often talked to himself. Prisoner G also remembered an incident when he saw the man and his cellmate talking to an officer, and the man appeared to be crying.
69. Prisoner L shared a cell with prisoner G and witnessed the man's cellmate being verbally abusive and aggressive towards prisoner G, to the extent that he was afraid to leave the cell. On one occasion the man's cellmate threatened to kill prisoner G, which concerned prisoner L so much that he asked to change cell.
70. Prisoner M was allocated a cell with the man's cellmate, and on their second day together, neither man had any tobacco. Prisoner M managed to get some from another prisoner, but he said that the man's cellmate said he was going to see a Listener to tell them that he felt suicidal and needed some tobacco.
71. Prisoner M was aware of his cellmate's offence, as he too had been in the hostel, and was surprised to see him on the wing. He spoke to his cellmate about it, and he produced a knife from his right sleeve. It was a toothbrush with the head snapped off and a razor blade melted into the handle. Prisoner M said his cellmate's explanation was that he had the knife as a precaution. Prisoner M said that, at around 8.00pm on 8 May, the man's cellmate returned to their cell with two officers, and did not speak but packed his belongings and left.
72. Prisoner N had been a prisoner at Leeds since February 2005, and he remembered the man's cellmate being transferred from A wing, but did not have much contact with him. He said that on one occasion the man's cellmate

asked what effect it would have on his sentence if he killed someone. He also told prisoner N that as he was already doing life, killing someone would not make any difference.

73. The second prison officer noticed that after the man started sharing a cell with his cellmate, they seemed to do everything together. He noticed that the cellmate took the lead and told the man what to do, but there is no evidence that any action was taken.
74. Another prisoner, prisoner O, worked as a cleaner on A wing. He was responsible for cleaning the communal areas and issuing razor blades on a new for old basis. He said that initially he had a favourable impression of the man's cellmate, but this had changed when he made a false allegation against his friend, prisoner E.
75. Prisoner P occupied cell A3:20 and he described the man as a quiet, sensible person who would keep himself to himself. The man had told him that he was due to be released on bail shortly, and was only waiting for a hostel place. His only contact with the man's cellmate was in an education class, when he said he was disruptive and easily angered. Prisoner P said that the man's cellmate shaved the man's head the week before his death.
76. Prisoner Q was another life sentence prisoner, and he occupied cell A4:05 with prisoner K. Prisoner Q knew the man and his cellmate, and described the man as a quiet, private person who shared his interest in word search puzzles. He last saw the man at the beginning of May 2006, when he said that the man seemed to be in good spirits and looking forward to being released from prison.
77. Prisoner Q was aware that the man's cellmate had previously shared a cell with prisoner D, who had been the wing hairdresser, but that he asked to be moved after a short period of time. Prisoner Q alleged that the man's cellmate said he would set fire to the cell, raise the alarm and give the impression that he had saved prisoner's D life. He said that the man's cellmate had also caused a problem in education when he alleged that two inmates were in possession of a gun.
78. Prisoner R was aware of a situation some time previously when the man's cellmate threatened to set fire to his cell. He said that his then cellmate, prisoner D, felt unsafe and asked to move. Prisoner R attended the Lifer group with the man's cellmate, and had formed the impression that he was unable to grasp the meaning of a life sentence.
79. Another prisoner, prisoner S, occasionally sat next to the man's cellmate in the art workshops. In the spring 2006, prisoner S was taken out of the class to the governor's office where he was shown a cardboard cut out of a hand gun and asked what he knew about it. He and his cellmate, prisoner T, were moved to the segregation unit, and subsequently prisoner S was told that the man's cellmate had alleged that they were going to use the gun in an attempt to escape. When the allegation was found to be untrue, they were returned to

their cell, which was located directly below that of the man who died and his cellmate.

9 - 10 May

80. A meeting of the Lifer's group was scheduled for the afternoon of 9 May, and prisoner R was asked to pass the information to the man's cellmate. He went to cell A4:02 at 2.00pm, and found the man sitting on the chair and his cellmate lying on the bottom bunk. Prisoner R thought that the atmosphere appeared jovial and he said that the man was laughing.
81. Prisoner S went to the group and told the chaplain that he did not want to attend any more meetings with the man's cellmate. Prisoner S then arrived and learnt that the man's cellmate was no longer welcome as he had caused problems with prisoner S and prisoner T.
82. The duty SO began her shift at 6.50pm on Tuesday 9 May, and was operationally responsible for the entire prison and visited the wings between 8.00pm and 9.00pm. The duty officer came on duty on A wing at 8.00pm and her main duties were to patrol the landings and answer any calls from prisoners. She carried a utility belt, containing a radio, pouch with scissors, a pouch with handcuff and keys and a baton pouch.
83. The duty officer began by checking the wing observation book for any current observations or problems with prisoners. There appear to have been no problems on the wing and no entries were made in the observation book. Each cell has a board on the outside identifying the occupants of the cell. The officer said she checked each prisoner by opening their cell hatch, although this was not recorded.
84. Prisoner U had shared cell A4:01 with prisoner G from when he arrived at Leeds on 4 May. From approximately 8.00pm on 9 May, the two men were locked in their cells where they watched television. During the evening prisoner U heard banging on the pipes from another cell, and the noise continued for some time, however he is unable to give an exact estimate.
85. Later that evening, at around midnight, prisoner S heard banging on the cell pipes and chairs being banged in the cell above. He said that the noise continued for about five minutes, and alternated between banging on the pipes and chairs being moved.
86. Prisoner W was in cell A3:3 and he too heard banging on the cell pipes. He described it as an initial loud bang, followed by several other bangs lasting three to four seconds. He said he could tell that the noise was not the usual sound of people banging the pipes with their spoons and cups, and thought it sounded like someone being hit with a fist or being kicked by someone who was barefoot.
87. Some 20 minutes after the noise stopped, prisoner S heard an alarm from cell A4:02, together with banging on the cell door and the sound of a man crying.

88. At about 11.10pm, the duty officer was on the wing with the duty SO and the Officer Support Grade (OSG). The officer heard shouting coming from a top floor cell and the SO heard a panicky voice shouting for help, followed by a wailing sound. They made their way upstairs and first went to cell A4:04, where a prisoner was on ACCT. As they approached the cells, the duty officer realised that the shouting was coming from cell A4:02. She turned the light on, opened the hatch in the door and said to her colleagues that the man was hanging.
89. The duty SO also looked through the hatch and saw the man suspended from the window, with a green bed sheet around his neck. He was facing the door, with both his arms at his side and his body was still. She noticed the man's cellmate sitting on the top bunk, approximately two and a half feet away, with their faces at the same height. He had a bed sheet pulled up around his chest.
90. The SO unlocked the door, instructed the man's cellmate to leave the cell and told the OSG to look after him. The SO took hold of the man around the waist and lifted him slightly, whilst the duty officer stood on the pipes below the window. The officer used a pair of scissors to cut the ligature between the window bars and the man's neck. They lowered the man to the floor and checked his pulse. No pulse was found and they began to administer cardio pulmonary resuscitation (CPR), the duty SO giving mouth-to-mouth resuscitation whilst the duty officer did chest compressions. The SO used her radio to request healthcare assistance, saying that a prisoner had been found hanging and there was a code blue emergency. (Code blue indicates that someone is experiencing breathing difficulties.) The Control Room log held by Leeds indicates that the calls went out over the radio network at 11.28pm, and the Control Room immediately telephoned 999 to request an ambulance.
91. Moments later, having heard a commotion on the top landing from his base in the Central Call Box between A, B, C and D wings, the wing officer arrived at the cell. He too checked for a pulse, and then replaced the duty officer administering chest compressions.
92. The staff nurse, who had been issuing medication to another prisoner, received the emergency radio call and immediately went to A wing. She found the officers attempting to resuscitate the man. The nurse checked his vital signs and found none, and then replaced the wing officer in delivering the chest compressions. She heard a crack and felt the man's breast bone give way, which is common when CPR is attempted. The nurse asked the duty officer to get the resuscitation equipment and the automatic external defibrillator from the second floor of the wing.
93. After the officer returned with the defibrillator, the staff nurse attached the pads to the man's chest and switched the machine on. There was a delay of a few seconds before the machine indicated that no shock should be delivered and CPR should be continued. CPR was continued and every 30 seconds the defibrillator gave an update of the man's status, each time advising not to shock. The duty nurse also heard the radio call and went to the cell, where he

took responsibility for giving chest compressions working alongside the staff nurse.

94. The Control Room log shows that a paramedic vehicle arrived at the prison at 11.34pm and the paramedics were escorted to the cell by the wing officer. The paramedics assessed the man's vital signs and carried out an electro cardiogram (ECG), which confirmed he had died. All efforts to resuscitate him were stopped and the paramedics pronounced him dead.
95. Shortly afterwards, at about 11.40pm, the duty SO asked the man's cellmate about his welfare. She told him that the man had died and asked whether he had given any indication of being depressed. The man's cellmate said that the man had received a letter from his wife, which ended their relationship, and also said that he was being bullied by two lifers. He said he had attempted to resuscitate him by touching his stomach. The cellmate was then moved to C wing, escorted by the discipline officer. She asked him whether the man had been having any problems and he repeated that he had been bullied by two lifers on the wing, which had been reported to officers. The cellmate did not identify the lifers' concerned. He also told the officer that he had been in a similar situation in a previous prison when his cellmate had taken his life.
96. The cellmate was subsequently interviewed by the police and gave a written statement that he had shared a cell with the man and they had got on well together. He said that the man was a very restless person who suffered from anxiety. He would pace the cell and constantly press the call buzzer. He said that the man had told him that he had recently spent some time in psychiatric hospitals, although he had not given any indication that he would take his life or harm himself.
97. The cellmate's statement continued that he and the man had watched television during the evening. The man did not appear to have any problems and he thought he was going to be bailed. The cellmate said that he fell asleep on the bottom bunk at around 9.00pm, and the man was sitting on the pipes at the rear of the cell watching a film. Later the cellmate said he woke up and turned on the light as the television and the DVD were still playing. He turned to face the window and saw the man hanging, perfectly still, from a ligature made of a green bed sheet. He said that he checked him, but he was not breathing and he could not find a pulse, so he then began to shout and kick the door. The cellmate said that the officers attended almost immediately and he was escorted from the area. He said that the man had not indicated that he had any thoughts of taking his own life.

After the man's death

98. On 10 May, under the instruction of the police, prison staff searched cell A4:02 and the third prison officer recovered a small piece of razor blade from under the pipes beneath the window of the cell. The Detective Constable (DC) interviewed the cellmate about the man's death and obtained a full statement from him, which he signed as correct. Both prison and police officers initially regarded him as a witness and he was not treated as a suspect.
99. The healthcare officer (HCO) was present when the DC took the statement from the cellmate. The HCO said that the cellmate said the man's mood was okay, then he had gone to sleep, waking to discover him hanging. Whilst recounting the events, the HCO said that the cellmate appeared to be telling a story as he was not animated, upset or agitated in any way.
100. The Registered mental health nurse (RMN) on duty on 10 May and was told that the cellmate had been admitted for observations and support. She assessed him at 10.30am and asked about events the previous evening. He told her that he had gone to bed early and was watching television. He had fallen asleep around 11.00pm and when he woke up his cell mate was hanging. When asked how he felt, he shrugged his shoulders and said he did not know. He said that he did not feel upset and the nurse thought that he appeared uninterested, and was giggling and laughing throughout.
101. A second RMN came on duty at 12.30pm and her attention was brought to a new inpatient, the cellmate. She knew that he was on the ward for observations and support, his cellmate having apparently taken his life the previous evening. At around 7.15pm, the second RMN was approached by her colleague, the HCO who told her that the man's cellmate was asking if he could move cells and share with someone.
102. The second RMN spoke with the man's cellmate and he said he had been told by the governor he could share a cell. However, the nurse had reservations about this as the HCO brought to her attention an entry in the cellmate's history sheet from the previous week. (This was the entry made by the education worker who had challenged the man's cellmate about his motivation to work within the group, when he said that he would take it out on his cellmate.) She told him that he had to be in a single occupancy cell, so staff could give better support. He was offered the services of Listeners or the Samaritans. His reaction to the man's death made her feel uneasy, as he did not appear affected by his experience, nor did he show any emotion.
103. The next day, 11 May, the second RMN was on duty again and at the start of her shift she was informed that the man's cellmate had cut his left forearm with a piece of glass. An ACCT self harm document was opened and he was monitored more closely. He again asked the nurse if he could share a cell with prisoner W, when he went back to the wing. He was told that it was not

- confirmed he would return to A wing and the request was not possible as both prisoners were on open ACCT documents.
104. Prisoner W was on A wing because he was a young man and it was his first sentence. He was transferred to the hospital wing on 9 May, after an incident in his cell, of which he was the victim. He was in the seating area next to the television during the evening and asked the man's cellmate why he was on the hospital wing. The cellmate explained that he had woken to go to the toilet and when he turned on the cell light, he found his cellmate hanging by his neck.
 105. Prisoner W was shocked by the explanation and asked the man's cellmate how he was coping with such an event. The man's cellmate replied that he had given his cellmate three choices: to hang himself, or he would slash him up or kick him. He also said that he had swung on his cellmates' legs and had cut his wrists to help him die. The man's cellmate told prisoner W that this was not the first time this had happened and he had done the same thing in another prison.
 106. On 12 May, the wing nurse noticed that the man's cellmate was quiet and slightly withdrawn. She saw that he was using a piece of glass to cut his arms and injure himself. She said that he appeared to be secreting pieces of glass about himself, as when one was recovered, he would continue with a different one.
 107. The man's cellmate was placed in the day room in an attempt to calm him down, whilst a close watch was maintained. The wing nurse and her colleague, the second wing nurse, spoke with him and he began to talk about his family history. He said that during his previous prison sentences he had given three different cellmates three choices. The choices were that the cellmate should either kill themselves, he would kill them, or he would slit their throat. He indicated that he occasionally had a razor blade in a toothbrush which he would use to cut people. He said he enjoyed controlling people, which gave him a 'buzz'.
 108. Later that day, the wing nurse spoke to the man's cellmate and he asked when the police were coming, as he said that he killed the man, going on to describe what he did. The following day the wing nurse answered the man's cellmate cell bell and he again spoke about killing people. He said that he would kill someone when he returned to the wings, as he had nothing to lose. He produced a piece of A5 paper, which she placed in his file. The contents disturbed her and it was recorded on a Security Intelligence Report (SIR).
 109. The HCO saw the man's cellmate again and thought that he appeared desperate to return to the wing to be with another prisoner, prisoner X. The man's cellmate was adamant he did not want to share a cell with a stranger and commented about what had happened to the man.
 110. The second HCO assessed the man's cellmate with his colleagues on 12 May. They discussed self harm and his feelings about returning to the main prison. The cellmate said he did not want to be with a stranger, and asked if he could be returned with prisoner W. He was told that this was not possible as no guarantees could be made regarding cellmates, and he then said that he

wanted to share with a Listener. The man's cellmate became annoyed and insisted he would not go in a cell with just anybody and might have to share with a stranger. He asked to return to his cell, saying that the same would happen to him as to the last one, but refused to explain his meaning.

111. In a separate conversation with the wing SO, the man's cellmate said that he would take his own life. Later in the day, the SO completed a Cell Share Risk Assessment and classed him as high risk. As a result of the assessment, the duty governor went to healthcare and told the man's cellmate that he would be in a single cell. The duty governor then left the wing, and the cellmate continued talking to the SO. He told her that in the past he had given prisoners three options. The first option was that he would kill the prisoner, the second that they should kill themselves. He then became emotional and digressed to an incident at HMP Moorland, when he said he forced a prisoner to cut himself at the throat.
112. The duty governor was informed of the conversation and returned to healthcare. He and the wing SO spoke with the man's cellmate at length and he told them that he needed to speak to the police. When asked for the reason, the cellmate referred to things he had done in the past, which he thought he had done again. He again explained the options which he gave his cellmates: that he would hang them, they would hang themselves, or they would have to cut themselves.
113. The man's cellmate explained that he had given the man the same three options when he found out that he was a sex offender. He said that there had been a scuffle between them, during which he had cut the man on his buttocks with a razor blade. He told the duty governor that they agreed that the man would hang himself and he would ring the cell bell to alert staff once he was hanging. He described cutting two strips off the bed sheet, an inch to an inch and a half wide, tying two knots and a loop. The other end of the sheet was threaded through the loop over his neck, and the cellmate then tied the bed sheet to the bars of the window.
114. He explained how the man climbed onto the top bunk, reminding him not to forget to press the bell when he jumped, as they had agreed. He said that the man had jumped, kicked his legs out for a short time, but had managed to get his feet onto the pipes and his arm on the top bunk. The cellmate said he pulled the man's arm away from the bed and pulled his legs down until the man stopped moving and his stomach filled with liquid. The cellmate said he got back into his bed and waited 30 minutes before alerting staff. He wrapped the razor blade in tissue and placed it in the toilet U bend. This information was then passed to West Yorkshire Police, whose criminal investigation followed.
115. The third wing nurse was aware of the duty governor and the wing SO officer talking with the man's cellmate and sat with him after the conversation was over. He said that the cellmate was reading the local newspaper. The cellmate referred to the newspaper report, and told the nurse that he had been involved in the man's death. He repeated to the nurse the three choices which he gave the man, going on to explain how he tore the sheet and knotted it into a noose

which he put through the window bars. He said that the man put his own head through the noose, and asked him to push the cell bell once he was hanging.

116. The cellmate told the third wing nurse that the man put his arms out towards the end of the bed when he started to hang, but he (the cellmate) pushed it away and removed his legs from the pipe. He left the man hanging for about 30 minutes whilst he cleaned the cell. He said he also cleaned the tops of the razors, used whilst they were fighting when he cut the man twice on his buttocks and once on his stomach. The cellmate told the nurse that he wrapped the razor blades in tissue, putting them down the toilet before pressing the bell to alert staff.
117. In June 2006, the common law wife of prisoner B, the prisoner with whom the man's cellmate had a sexual relationship, received a letter from the man's cellmate. The letter was addressed to her but the content was to be forwarded to prisoner B. In the letter he described the man's death, repeating that he initially told staff that he was asleep at the time, but that he later made a full admission to the governor.

Post Mortem and Toxicology

118. The post mortem was conducted by a pathologist who concluded that the man's death was due to hanging. The ligature mark was consistent with having been caused by a piece of bed sheet. The injuries on his buttocks were not contributable to his death. There were no obvious injuries other than trivial ones to his hands. There were no restraint marks or any marks indicative of any form of assault.

FAMILY ISSUES

119. The man's family asked a number of questions about his location and treatment within the prison, some of which have been answered already and the remainder are addressed below.

Why was the man located on a normal wing, when he had just come out of hospital and had mental health problems?

120. A study carried out by the Office of National Statistics on the mental health of the prison population in England and Wales indicated that approximately 90% of prisoners suffer from some sort of mental disorder. It is not possible for all of these prisoners to be located on specialist healthcare units, and therefore the Prison Service attempts, as far as possible, to prioritise those most in need.

121. The head of healthcare at Leeds explained that, on admission into the prison, every prisoner is seen by a healthcare professional and an assessment carried out. During this process a risk assessment is undertaken and consideration given to opening an ACCT document. The man's demeanour did not raise concerns and so an ACCT document was not considered necessary.

122. The fact that a prisoner has been in hospital, does not necessarily mean that further hospitalisation is needed. Having been discharged from either a mental health or a physical health facility indicates that the consultant in charge of their care considers them fit to be discharged into their own homes and treated within the community. The normal wings in the prison are regarded as equivalent to returning to their own home without in patient nursing care.

123. The clinical reviewer comments that healthcare should follow up prisoners such as the man, who are charged with serious offences and have displayed sufficient symptoms to warrant detention under the Mental Health Act.

The Prison Health Partnership should agree a clear clinical pathway to follow up prisoners charged or convicted of serious offences who display sufficient symptoms to warrant consideration for detention under the Mental Health Act or have been recently subject to detention in a mental health unit.

What are the criteria for admission to healthcare?

124. In patient admission to healthcare is based primarily on clinical need. Nursing staff, general practitioners or the Mental Health Inreach Team usually make the decision to admit someone to healthcare. In the event of wing staff raising concerns about a prisoner, the healthcare manager would consider the situation and could decide that a period of assessment is indicated. The unit also looks after patients awaiting transfer to other secondary care facilities.

How many cells and cellmates did the man have during his time within the prison and what necessitated the moves?

125. The man had a number of cell moves and cellmates whilst in prison. This information is described in full in paragraphs 54 to 61.

Why was the man placed in a cell with a prisoner serving a life sentence even though he was on remand and not convicted?

126. The information from the prison is that efforts are normally made to try to locate life sentenced prisoners in a cell on their own. However, this is not always possible due to prison population pressures. There is no policy for segregating remand and sentenced prisoners, and instead the Cell Sharing Risk Assessments (CSRA) determines where they are located. I make further comment further on Leeds' use of Cell Sharing Risk Assessments in the rest of my report.

Whether a risk assessment was carried out when the man shared cells, what it showed, and how it led to him being located with his last cellmate?

127. The man's family are rightly concerned that he was placed in a cell with a man later described by the sentencing judge as dangerous.

128. I have already reported that CSRAs were completed for both the man and his cellmate when they arrived at the prison. The man's CSRA showed that he posed a low risk to other prisoners and was therefore deemed suitable to share a cell. The cellmate's initial CSRA came to the same conclusion, although this was subsequently upgraded to a medium risk level. Unfortunately, the officer who placed them together did not have access to the amended CSRA. However, as it is only high risk prisoners who are located in single cells, the cellmate was still deemed suitable to share a cell.

Was the man's cellmate known to present a risk to alleged or convicted sex offenders?

129. In February 2006, the cellmate was interviewed by a probation officer for a pre-sentence report concerning the fire at the probation hostel. The report was prepared for the court and would have been forwarded to the prison after he was sentenced. It states that, in the days preceding the offence, the cellmate:

'became increasingly frustrated with the rules of the hostel. In addition, he had borne a grudge against two residents at the hostel. He explains that this was due to them being from Yorkshire and that he was from Nottingham. He is of the opinion that there is an ongoing hostility between the people of the two areas'.

130. The report goes on to comment on the risk of harm he posed to the public. It says:

'The Thornton Risk Matrix 2000 [an assessment tool which predicts the risk of violent offending] ... rates him as very high risk. Using the OASys [Offender

Assessment System] risk assessment tool, he is assessed as posing a very high risk of harm to the public.

131. The report continues:

'In the interview he [man's cellmate] continued to express antagonistic attitudes and threats to [the] hostel and two of its residents. His previous pattern of behaviour suggests that he targets vulnerable people such as children and the disabled. He is clearly a risk to statutory agency staff and those in authority. He also expressed racist sentiment towards Asians. I view that he poses a risk of serious harm to the public'.

132. Whilst the risks described by the probation officer are extremely concerning, no mention is made of sex offenders being specifically at risk, and it was understandable that the prison did not identify that they might be vulnerable.

133. I describe earlier that another prisoner alleged that he told an officer that the man's cellmate should not be located in a cell with a paedophile. Unfortunately my investigators have been unable to establish the identity of the officer and the information was not recorded in the cellmate's records. The man was not on remand for offences against children.

134. At the time of the man's death, the prison and probation services had little reason to think that the cellmate posed a specific risk to sex offenders. He said that his reason for attempting to kill the hostel residents was because they came from Leeds and he came from Nottingham. He had a history of violent behaviour directed at vulnerable individuals, but none of his previous victims had been sex offenders. Research on the subject of predicting risk finds that the most accurate indicator of future behaviour is past behaviour. The cellmate was not, therefore, assessed as someone who posed a risk to sex offenders.

Why were there obvious ligature points within the cell?

135. Following his assessment by the Safer Custody department on 29 April, the man was not deemed to be at significant risk of self-harm or suicide. As such he was not located in a safer cell, which are designed to reduce risk by minimising ligature points. Cell A4:02 was an ordinary cell.

The man's healthcare

136. The man's family raised a number of questions about what the prison knew of his health needs and the level of health care he received within the prison.

137. The head of healthcare said that these questions come into the realm of patient confidentiality, and therefore would not give specific answers. However, in general terms it can be said that the prison would seek information from both the community general practitioner and, depending on the prisoners presentation, liaise with the Mental Health In Reach Team to follow up any previous mental health treatment. The man was not receiving any medication nor had he been seen by the mental health team. I have already commented

that, as a prisoner who had required treatment under the Mental Health Act, he should have been followed up by healthcare professionals after he was remanded in custody.

The man told his family that he was locked up for 23 hours a day and they would like the investigation to detail the daily regime within the prison.

138. Although it is not mandatory for remand prisoners to go to work or undertake education classes, work and education is available. The man chose not to take advantage of the opportunities. It is therefore likely that he spent a significant amount of time in his cell.

How was the alarm raised and responded to?

139. This is described in paragraphs 81 to 88, above.

Why was the man's elderly mother telephoned at 5.15am and asked for her address? She was visited at her home by the deputy governor and five police cars were in the vicinity.

140. The prison was asked to respond and said that the prison's representative visited the man's next of kin in the company of the chair of the Independent Monitoring Board and one police officer. The police officer was asked to be present in order to show prison staff where the man's mother lived. The prison was unaware of the number of police vehicles in the area until after the visit had taken place.

141. The prison has advised the man's family take the matter up with the local police. My family liaison officer has provided them with the relevant details to do so.

Was the man asked for his next of kin details on reception?

142. The first entry on the man's History Sheet is dated 28 April and it records his next of kin as his son, giving his address and a telephone number.

The family also asked my investigators to access the press release that was distributed following the man's death as they had concerns about the amount of information that became public.

143. The following is the extract from the Home Office, Press Bureau.

'There have been two self inflicted deaths at HMP Leeds - on Tuesday 9 May and Wednesday 10 May. Both prisoners were held in completely separate areas of the prison and the deaths are not linked.

We can confirm the death in custody of the man on Tuesday 9 May 2006 at HMP Leeds. He was found hanging in his cell at 11.20pm. Staff and paramedics attempted to resuscitate him but he was pronounced dead at 11.50pm.

The police, coroner and next of kin have been informed.

The man was on remand awaiting sentencing for false imprisonment. He had been in custody at HMP Leeds since 28.04.06. He had not been identified as being at risk of self-harm and was in a shared cell.

Every death in custody is a tragedy, and our sympathies are with the family and friends of the man ... at this time. As with all deaths in custody, the Prisons and Probation Ombudsman will conduct an investigation into both of these cases.

There were two deaths at HMP Leeds in 2005, and there have been four deaths in the prison this year [2006]’.

ISSUES CONSIDERED IN THE INVESTIGATION

Cell Sharing Risk Assessments (CSRA) – Initial Assessment

144. I have described the CSRA system and how it applied to the man who died and his cellmate. Despite being arrested for a serious sexual offence, the man's lack of previous convictions and his attitude and behaviour at reception meant that he was identified as a low risk to cellmates. In my view this was entirely appropriate and I therefore have no further comment to make on this aspect of the man's story. However, I do have concerns about how well the system worked in the cellmate's case.
145. The man's cellmate arrived at Leeds with very little accompanying information. Indeed, the CSRA completed on him by the reception officer on 3 January, indicates that only the Prisoner Escort Record (PER) and the warrant for his detention were available. It therefore follows that the officer had to rely heavily on the cellmate's verbal responses in order to fill in the form. This in itself is problematic. Research conducted by the Research Development and Statistics department of the Home Office into the CSRA forms in 2003, showed that the information gleaned from the prisoner interview was only accurate 45% of the time. However, in the absence of any other means of answering the questions, 45% accuracy is significantly better than leaving the form blank.
146. Using the limited documentation available, the reception officer was able to record that the man's cellmate had previous convictions for assault and arson. She went on to note that he had not been convicted of a racist or homophobic crime, but that his current offence was one of a lengthy list which included arson. She recorded that he had previously damaged property, but that there was no evidence of various anti-social behaviour, including bullying, unpredictable / unexplained aggression, hate motivated behaviour, assault on staff, or assault on others. She also indicated that he had abused alcohol or drugs, but was not currently dependent on drugs. There was no current self-harm document in place, but the cellmate told her that one had been opened previously.
147. Finally the man's cellmate was asked whether he had any concerns about sharing a cell and whether he described himself as someone who gets angry or frustrated quickly. The answer to both questions was recorded as negative. Despite the limitations of the sources of the reception's officer information, she managed to complete the CSRA accurately. However her conclusion, that he was a low risk with no current evidence of risk and suitable for multi-cell location, is questionable.
148. As a busy Category B local prison, Leeds processes hundreds of prisoners through reception every week. In previous reports I have commented that the sheer numbers of prisoners passing through reception necessarily militates against the effective operation of CSRA. That said, and whilst being sympathetic to the conditions in which the Cell Sharing Risk Assessments are completed, I am surprised at the conclusion of the assessment. It is alarming that a man with previous convictions for arson and assault, charged with

deliberately setting fire to a probation hostel two days previously, and who admitted smashing up his cell whilst a young person, was deemed to be low risk.

149. The form contains trigger questions which should prompt the assessor to adjust, and if appropriate, upgrade their view of the risk level. In the additional information box under question four on Section Two, useful information about the man's cellmate's behaviour whilst in custody previously has been recorded. Although in all likelihood it would not have altered where he was located that night or in the weeks to come. If he had been assessed as a medium risk it would have alerted wing staff to the fact that the man's cellmate is a prisoner who needed to be monitored.

Cell Sharing Risk Assessments (CSRA) – Risk Review

150. In the event, apparently nothing untoward happened during the man's cellmate's first days in the prison. More than a fortnight after admission to Leeds, an officer spoke to him and examined his paperwork so that he could be allocated to an appropriate cell. She concluded that he should not be classified as low risk and asked a more senior colleague to arrange a risk review.
151. For reasons my investigators have been unable to ascertain, he was not reviewed for another four weeks and I am not convinced that the review was prompted by the officer's request. The delay is unacceptable.
152. When the review took place, it integrated information from the National Probation Service and took account of the cellmate's threat to harm prisoner G. Although the review resulted in his risk being upgraded to medium, the form was incomplete and omitted the Risk Minimisation Plan.
153. The guidance and instructions on how to implement the CSRA process state that a plan must be in place to manage any high or medium risks identified. It must be agreed within seven days of the review and signed by the duty governor. The plan should form the core of the prisoner's history sheet and a copy should be kept on the wing file. The plans should be consulted whenever prisoners are relocated and can be cancelled, confirmed or revised at any subsequent review.
154. The absence of a plan for the man's cellmate transpired to be a grave error. The form did include some amendments to his ACCT plan, but this is not the purpose of the CSRA. ACCT focuses on the individual and the CSRA focuses on the cellmate. In this case the ACCT amendments would not have addressed the risks identified by the probation service. Medium risk was identified, including threats to kill another inmate, a deep hatred of Asians and previous threats to smash up were recorded as explanation. I fail to see how locating someone in a shared cell, increasing the level of ACCT observations at night time and / or moving him to another wing would minimise the risk posed to cellmates. The Cell Sharing Risk Review document completed on 20 February is poor.

155. One of my investigators interviewed the governor responsible for CSRAs at Leeds, and raised his concerns about the Cell Sharing Risk Review carried out on 20 February. The governor explained that there is currently little guidance to help frontline staff complete these reviews. He suggested that the actions listed probably do not do justice to the actual amount of work done with the man's cellmate.

The governor must satisfy himself that he has in place appropriately robust management checks of the CSRA forms in accordance with prison policy..

The man's move to cell A4:02

156. On 30 April, the man was moved from cell A4:28 to A3:25 before being moved again later in the day to A4:02, to share with his last cellmate. The movements' officer said that A4:02 was the only cell with a vacant space that day and, after checking the cellmate's CSRA, he authorised the move. He noted that the CSRA recorded the man's cellmate risk to cellmates as low and so he either referred to his first CSRA or he misread the Risk Review.

157. In a busy local prison with large numbers of daily movements in, out and around the prison, frontline staff do not necessarily have the time to read all the documentation held on each prisoner. As the Risk Review form is in a different format to the CSRA, it would be easy for an officer to overlook it whilst he or she searches for the more familiar CSRA.

158. Consequently, whilst I do not know whether the officer misread the Cell Sharing Risk Review or referred to the original CSRA, I suggest that whenever a Cell Sharing Risk Review is carried out, the officer(s) should be looking for Cell Sharing Risk Review and minimisation plans. It is important that the most up to date information is noted. Review forms allow for more specific information about the exact nature of the risk and give a clear indication of the risk rating. The review rating should be clearly noted on the review form and this should be attached to the history sheet and wing file.

The Cell Sharing Risk Review rating should be clearly noted on the review form and this should be attached to the history sheet and wing file and if appropriate a minimisation plan initiated within seven days.

Availability of places in approved premises

159. The tragedy of the man's death is accentuated by the failure to bail him to an approved premises, despite the orders of two Crown Court judges. The first order was imposed seven days before he died and the second only four days beforehand. Had a place been found, the man may well have lived.

160. I am aware of the pressure for beds and also of the care taken to offer scarce places to the most appropriate offenders. I have not considered this aspect of the man's circumstances in my investigation, and so make no recommendation. Nevertheless the governor may wish to draw my report to the Chief Probation

Officer and Regional Offender Manager in order that they can consider their own investigation.

RECOMMENDATIONS

The Governor must:

1. Satisfy himself that he has in place appropriately robust management checks of the CSRA forms, including Cell Sharing Risk Reviews, to ensure they are completed in full at all times.
2. The Cell Sharing Risk Review process must result in a new CSRA being completed if the risk level changes.

The Primary Care Trust should:

3. Agree a clear clinical pathway to follow up prisoners charged or convicted of serious offences who display sufficient symptoms to warrant detention under the Mental Health Act.